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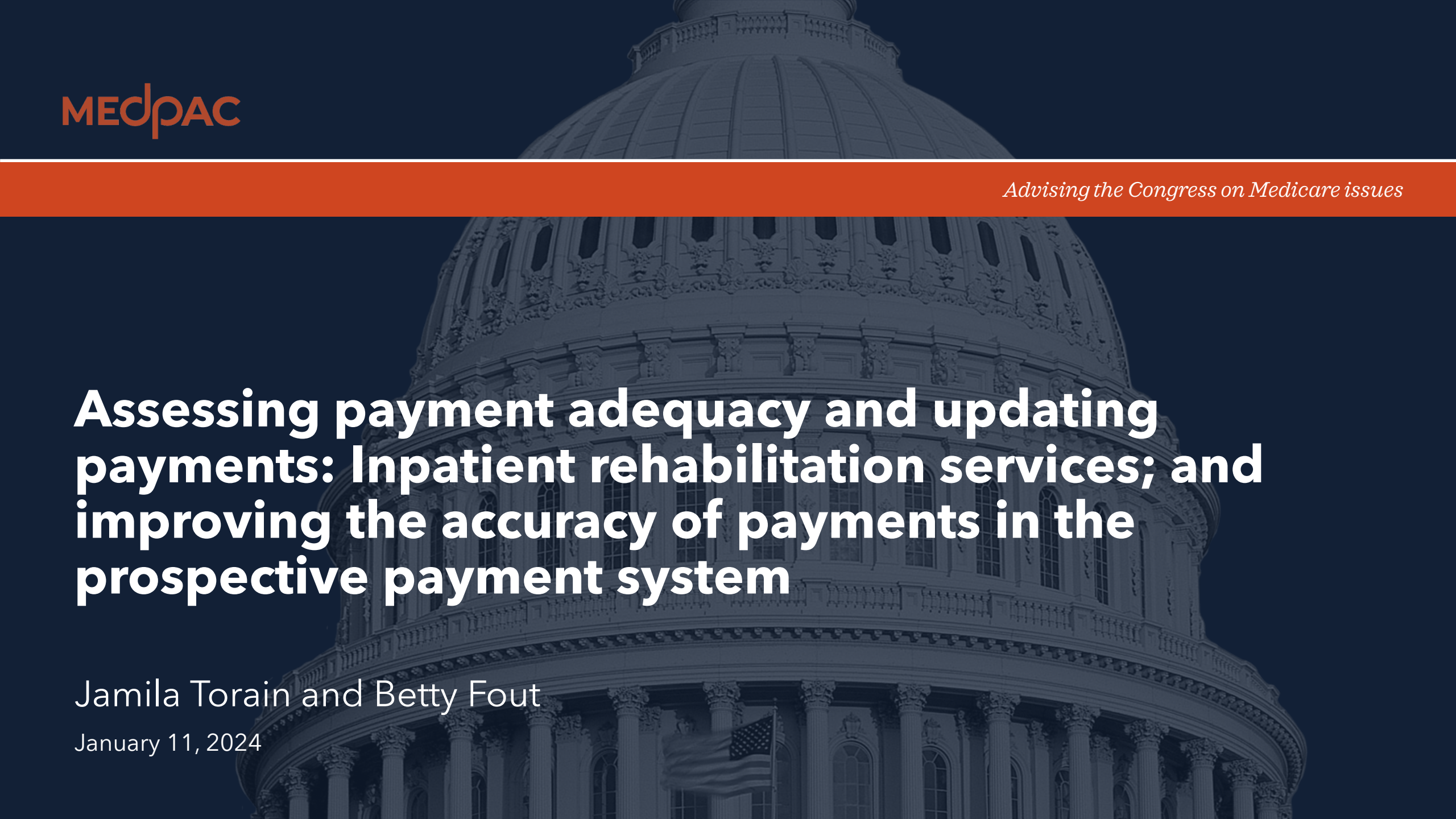

Assessing payment adequacy and updating payments: Inpatient rehabilitation services; and improving the accuracy of payments in the prospective payment system

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Presentation roadmap

1. Overview of IRF use and spending under FFS Medicare
2. Review of payment adequacy indicators
3. Improving the accuracy of payments in the IRF PPS

Overview of IRF use and spending under FFS Medicare, 2022

IRF Providers 1,181

Stays 383,000

Spending $8.8 billion

FFS Medicare share 51% of all IRF discharges

Note: IRFs (inpatient rehabilitation facilities), FFS (fee-for-service).
Source: Provider of Services data, Medicare Provider Analysis and Review data, and Medicare cost report data from CMS and Office of the Actuary.

Summary: IRF payment adequacy indicators

Beneficiaries' access to care

- Capacity appears adequate
- Occupancy rate stable at 68%
- 2022 FFS Medicare marginal profit:
  - FS: 39%
  - HB:18%

Quality of care

- Facility rate of discharge to the community improved to 67.3%
- Facility rate of potentially preventable readmissions was 8.6%

Access to capital

- Hospital-based IRFs access capital through their parent institutions
- 2022 freestanding all-payer margin: 9%

FFS Medicare payments and costs

- 2022 FFS Medicare margin: 13.7%
  - FS: 23%
  - HB: 1%
- 2024 projected margin: 14%

Note: IRFs (inpatient rehabilitation facilities), FS (freestanding), HB (hospital-based), IPPS (Inpatient prospective payment system).

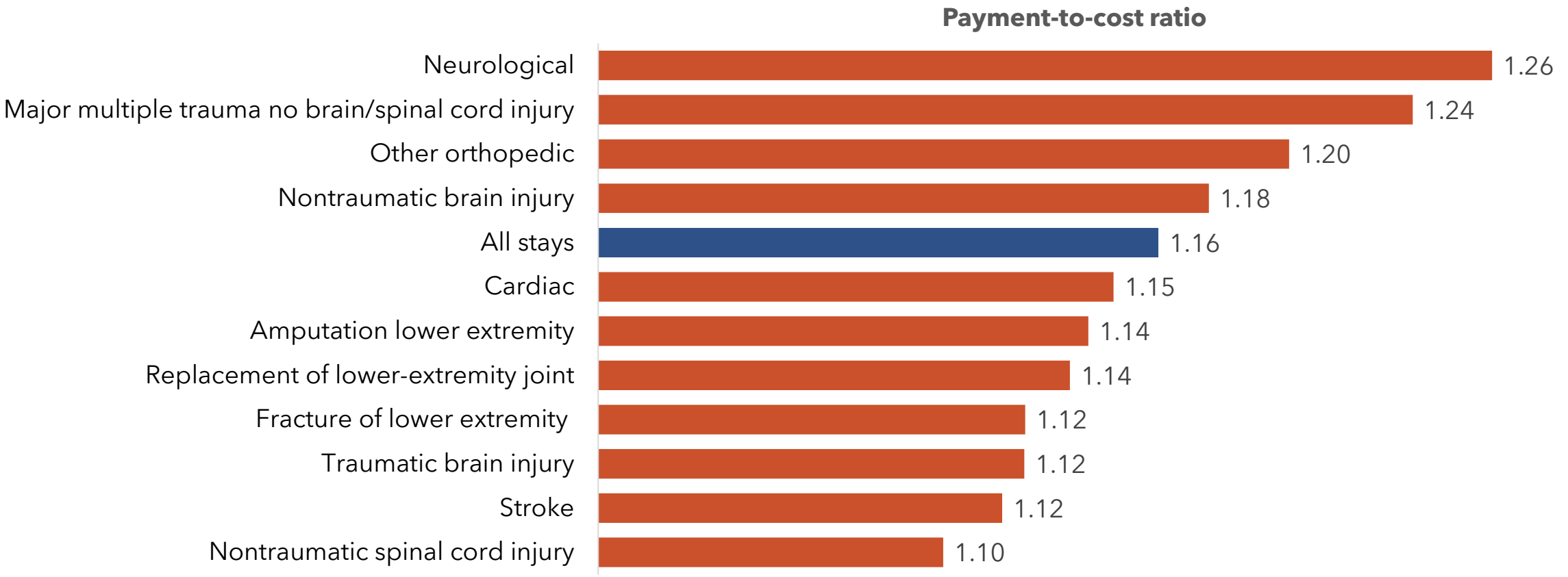
Improving the accuracy of payments in the IRF prospective payment system

Improving the accuracy of payments

- Previously reported on differential profitability across case type (March 2023 report to the Congress)
- Differential profitability may create financial incentives to admit certain types of patients over others
- The Commission decided to conduct further analysis into drivers of these patterns
- We identified a change in the method use to set IRF PPS weights that would result in more uniform profitability across case types

Note: IRF (inpatient rehabilitation facility), PPS (prospective payment system).

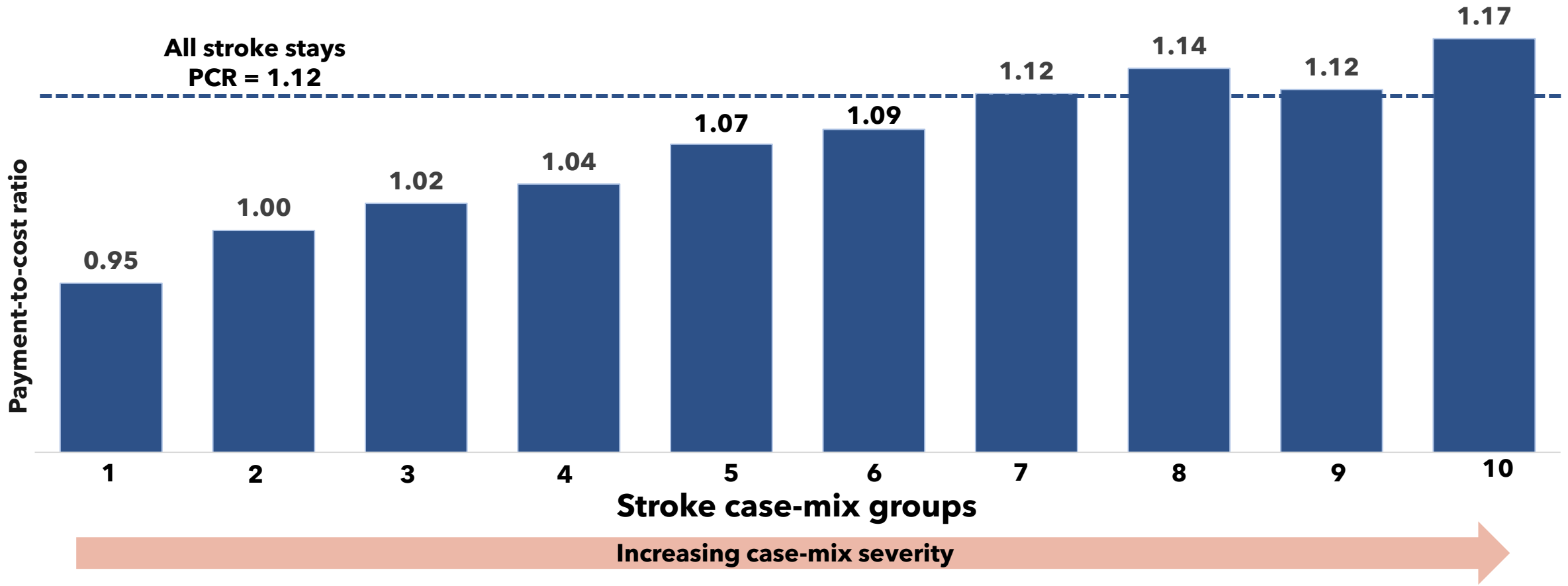
Profitability varies by IRF condition, 2019



Note: IRF (inpatient rehabilitation facility). The figure includes high-volume rehabilitation impairment categories. Payment-to-cost ratios are calculated by dividing summed payments by summed costs for stays assigned to each category.

Source: Urban Institute analysis of Medicare fee-for-service claims and cost reports from CMS.

Profitability increases with severity of case-mix group for stroke stays, 2019

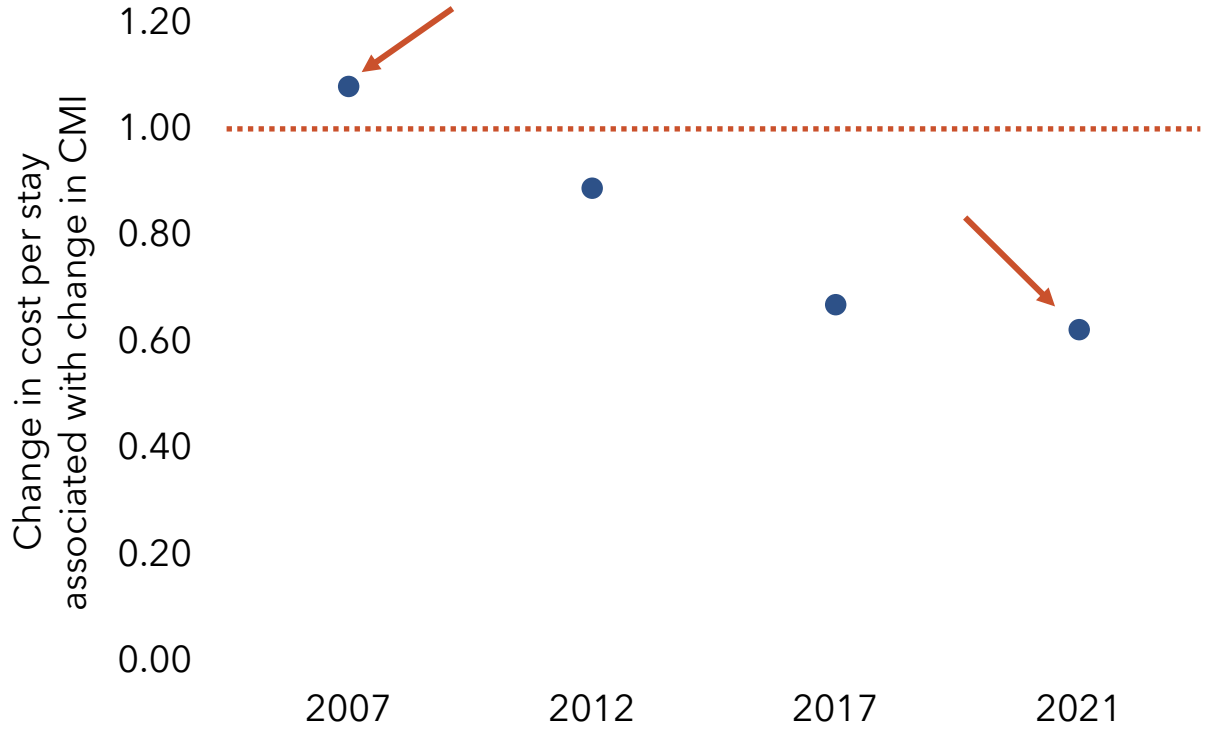


Note: PCR (payment-to-cost ratio). Payment-to-cost ratios are calculated by dividing aggregate payments by aggregate costs for stays assigned to each stroke case-mix group. Case-mix groups are determined by the patient's functional impairment, cognitive impairment, and age.

Source: Urban Institute analysis of Medicare fee-for-service claims and cost reports from CMS.

Relationship between IRFs' case-mix index and average cost per stay is no longer proportional

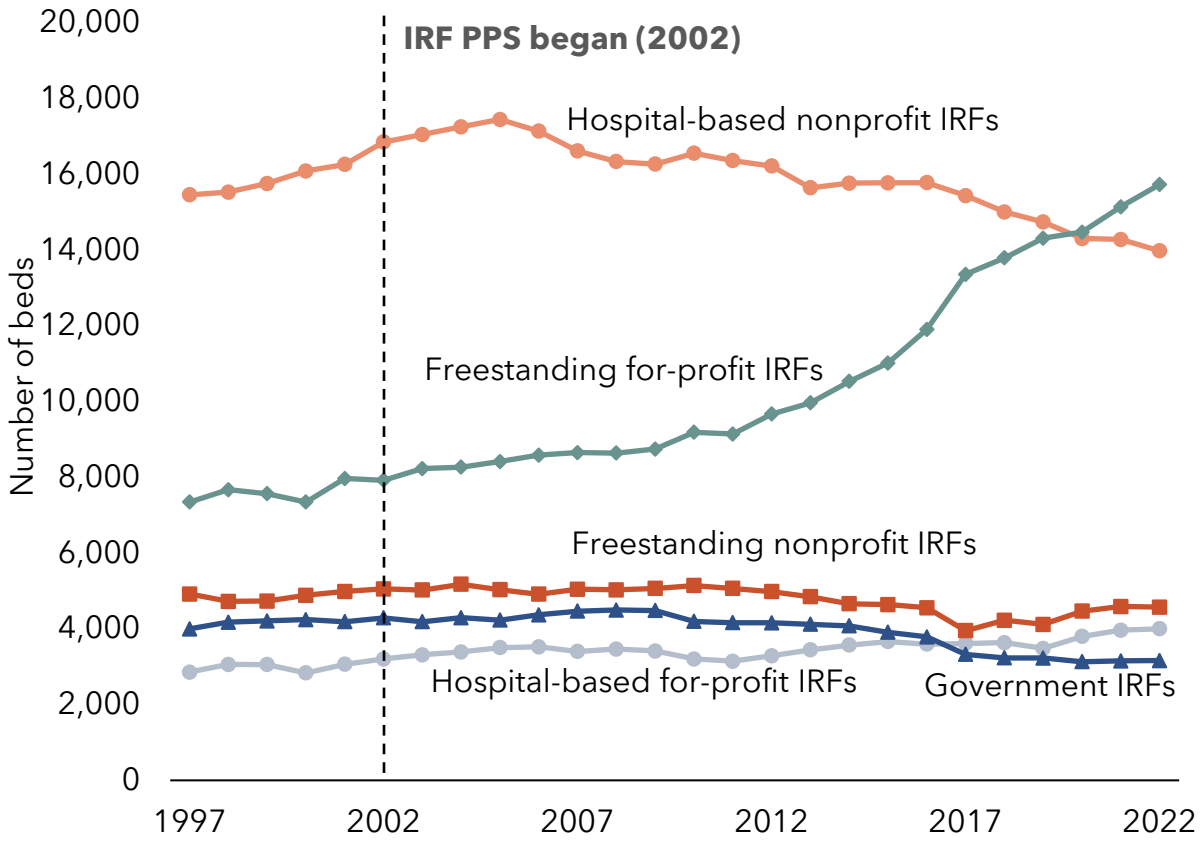
- The CMI is the IRFs' average payment weight; it measures the severity of an IRF's stay
- In 2007, a change in CMI was associated with a proportional change in costs
- By 2021, a change in CMI was associated with a less-than-proportional change in costs



Note: IRF (inpatient rehabilitation facility), CMI (case-mix index). Each point represents the coefficient estimated on a log-log regression of IRFs' average cost on CMI, controlling for IRF characteristics. Each coefficient shown in the figure represents the percent difference in costs associated with a 1% increase in CMI.

Source: Urban Institute analysis of the IRF prospective payment final rule rate-setting files for FY 2009 through FY 2023.

Number of beds in lower-cost IRFs grew substantially, 1997–2022

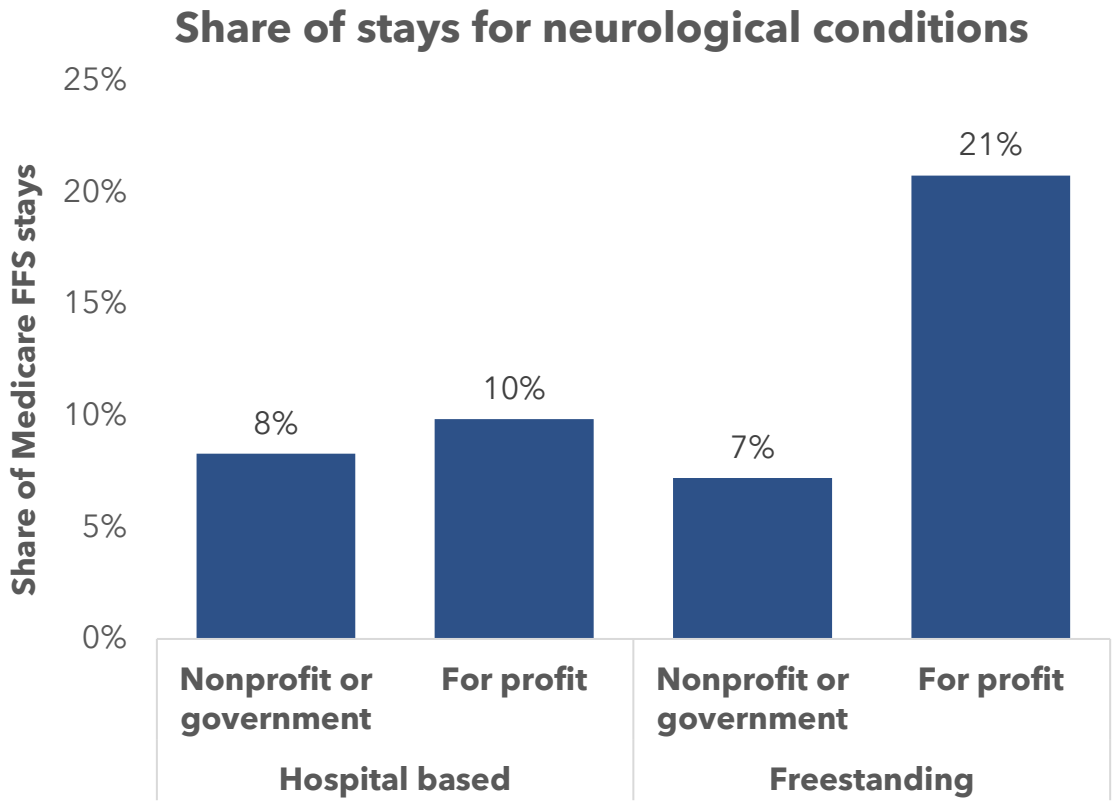


Note: IRF (inpatient rehabilitation facility), PPS (prospective payment system).
Source: MedPAC analysis of Medicare cost report data from CMS.

- Hospital-based IRF beds predominated until relatively recently
- Freestanding for-profit IRFs tend to be larger and have lower costs per stay than hospital-based IRFs (30% lower, on average, in 2022)

IRFs vary in the types of stays admitted and coding practices

- Freestanding for-profit IRFs admitted a relatively high share of neurological stays compared with other types of IRFs
- The Commission previously reported on differential coding of stays among IRFs



Note: FFS (fee-for-service), IRF (inpatient rehabilitation facility).
Source: MedPAC analysis of 2021 Medicare fee-for-service claims from CMS.

Average-cost weighting method would reduce profitability differences across IRF case types

Hospital-specific relative value (HSRV) method

- CMG payment weights are set to be proportional to *within-IRF* relative costs per stay
- Weight changes if relative costs within IRFs change

Currently used in the IRF PPS

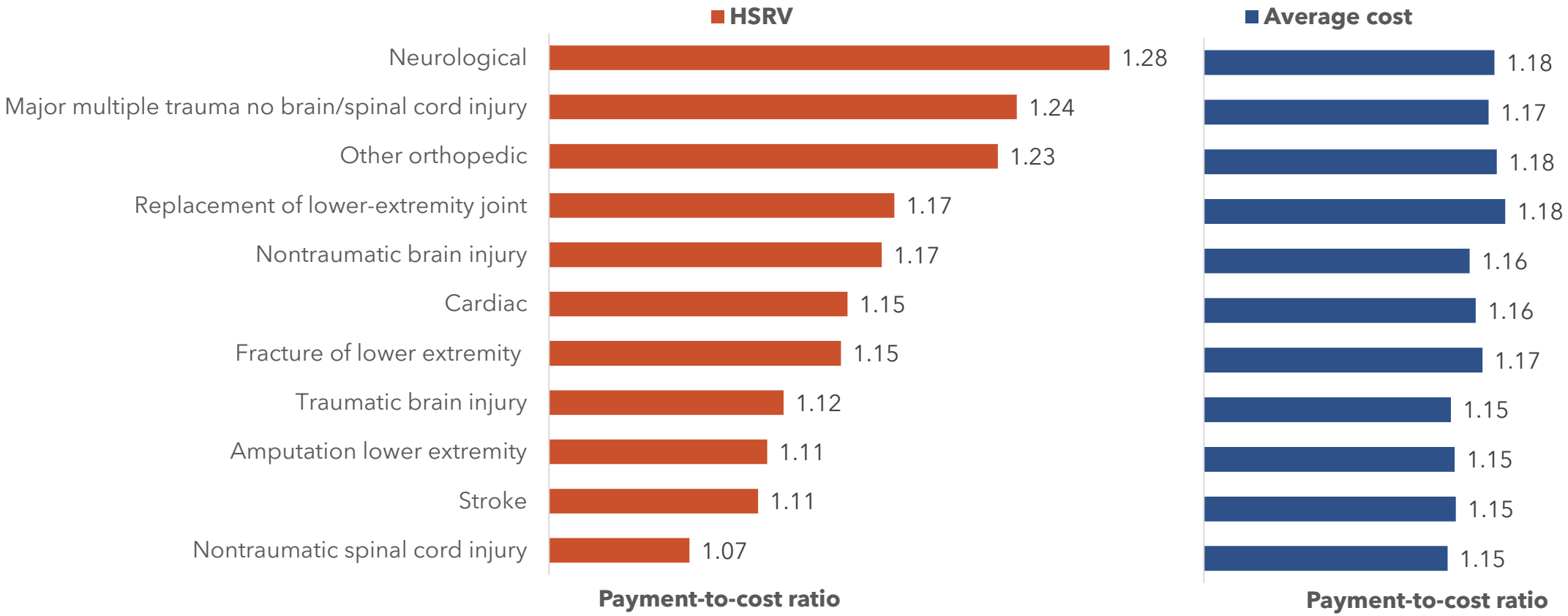
Average-cost method

- CMG payment weights are set to be proportional to costs per stay *across IRFs*
- Weights decrease if lower-cost IRFs concentrate in a type of case

Currently used in the IPPS and SNF PPSs

Note: IRF (inpatient rehabilitation facility), HSRV (hospital-specific relative value), CMG (case-mix group), IPPS (inpatient prospective payment systems), SNF (skilled nursing facility).

Average-cost weights yield more uniform profitability by IRF condition, 2019



Note: IRF (inpatient rehabilitation facility), HSRV (hospital-specific relative value). Payment-to-cost ratios are calculated by dividing aggregate payments by aggregate costs for stays assigned to each rehabilitation impairment category. Payments were calculated based on the Urban Institute's simulation of HSRV and average-cost weights.

Source: Urban Institute analysis of Medicare fee-for-service claims from CMS.

Average-cost weights would shift dollars to hospital-based nonprofit and small IRFs, 2019

- Estimated budget-neutral impacts on payments of replacing HSRV with average-cost weights
- Impacts depended on the types of cases IRFs tend to serve
  - Hospital-based nonprofit IRFs (↑ 2%); small IRFs (↑ 2.5%)
  - Freestanding for-profit IRFs (↓1.5%); large IRFs (↓1%)
- Actual impacts will differ based on cases IRFs treat and any behavioral changes
- Average-cost weights affect the accuracy of payments across stays but not the overall level of payments

Note: IRF (inpatient rehabilitation facility), HSRV (hospital-specific relative value). Impacts were estimated by subtracting simulated HSRV-based payments from simulated average-cost-based payments divided by HSRV-based payments. IRF size was based on number of fee-for-service Medicare stays in the year.

Source: Urban Institute analysis of Medicare fee-for-service claims from CMS.

Considerations for moving to average-cost payments weights

- Changes in statute not needed
- No added administrative burden on providers
- May help to reduce financial incentives to admit certain types of patients over others or to code patients as more functionally impaired
- Necessary to continue monitoring and auditing utilization of IRF services and the accuracy of the provider-reported assessment data

Note: IRF (inpatient rehabilitation facility).

Next steps

- Questions?
- Discussion
- Incorporate Commissioner feedback and include in the March 2024 IRF payment update chapter

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